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OFFICE OF POLICY AND MANAGEMENT

TESTIMONY PRESENTED TO THE HUMAN SERVICES COMMITTEE
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Benjamin Barnes
Secretary
Office of Policy and Management

Testimony Supporting House Bill No. 6846

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS

Good afternoon, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. Thank you for the opportunity to offer testimony on House Bill No. 6846, An Act Implementing the Governor's Budget Recommendations for Human Services Programs.

The initiatives in this bill will result in savings of $82.0 million in FY 16 and $141.8 million in FY 17 ($161.6 million in FY 16 and $271.8 million after factoring in the federal share). For your reference, I have included an explanation of the various sections of the bill at the end of my testimony. For today, I would like to focus my remarks on the changes in the budget related to the transition of coverage to Access Health CT, the state's health insurance marketplace.

Since enrollment began on October 1, 2013, Access Health CT has enrolled over 110,000 individuals in qualified health plans. With the previous barriers to accessing quality, affordable health care coverage removed, the Governor is proposing to transition coverage for adults (including pregnant women) under HUSKY A with income over 138% of the federal poverty level (FPL) to qualified health plans sold through Access Health CT. According to the Kaiser Family Foundation, as of January 2015, Connecticut was the only state plus Washington D.C. still providing coverage to parents and/or other adults with income over 138% FPL ($33,465 for a family of four). While I recognize that the vast majority of states do provide coverage to pregnant women with income over 138% FPL ($21,983 for a family of two (to reflect the mother and her expected child)), only four states limit coverage to pregnant women with income at or below 138% FPL, the Governor's proposal recognizes the comprehensive coverage available through Access Health CT and the opportunity to realign services as a result of the Affordable Care Act. It is projected that approximately 34,200 adults (including pregnant women) on HUSKY A with income over 138% FPL will transition to Access Health CT. This represents less than 5% of total Medicaid enrollment, which as of January 2015 was approximately 723,800. Coverage for children enrolled in HUSKY A will not be affected by this proposal.

In addition, the Governor is proposing to eliminate HUSKY B Band 3, which serves children whose families' incomes are over 323% FPL ($78,327 for a family of four) and is unsubsidized. Given the availability of affordable health insurance, there is no need to continue to administer this component. As of February 1, 2015, enrollment under Band 3 was down to 227 children.

Lower income households purchasing health insurance through Access Health CT will qualify for significant federal subsidies lowering the costs associated with obtaining and maintaining comprehensive health insurance coverage. Federal subsidies include advanced premium tax credits to reduce the monthly cost of health insurance premiums for a silver level plan, as well as additional cost sharing reductions, lowering the out-of-pocket, point-of-service costs for obtaining medical care and/or prescription drugs.

2015 Silver and 2015 Silver Cost-Sharing Reduction (CSR) Alternatives - Qualified Health Plans - Single Individual, Age 30, Hartford County

Income Band (FPL)	Plan	Monthly Premiums *(cheapest silver plan)*	Co-Pays			Out-of-Pocket Max
			Primary Care		Tier 1 Generic Drugs	
			Preventative Visit	Non-Preventative		
138-150%	94% CSR	$48.26	$0	$20	$5	$600
151-200%	87% CSR	$104.18	$0	$20	$5	$1,750
201-250%	73% CSR	$127.42	$0	$30	$5	$5,200
>250%	70% Silver	$219.60	$0	$30	$5	$6,600

Note: The CSR subsidies are based on a plan's actuarial value - the percentage of the average user's yearly medical expenses that the plan is designed to pay.

In conclusion, in the face of rising Medicaid costs and growing caseloads, the Governor's budget takes advantage of savings opportunities under the Affordable Care Act, allowing the state's limited resources to be directed towards maintaining critical services. In addition, the changes proposed by Governor Malloy will strengthen the viability and sustainability of the state's health insurance marketplace – helping to ensure that Connecticut's residents have access to health care in the years to come.

I would again like to thank the committee for the opportunity to present this testimony. I respectfully request that the Committee support this bill and I would be happy to answer any questions you may have on these sections or any other sections of the bill.

Section-by-Section Explanation. House Bill No. 6846 makes the following changes:

Section 1. Limit Pilot Community Ombudsman Program to within Available Appropriations. PA 13-234 expanded the duties of the State Long Term Care Ombudsman to include, on and after July 1, 2014, implementing and administering a pilot program that serves home and community-based care recipients in Hartford County. $26,600 was first appropriated in FY 15 for this purpose. The State Department on Aging (SDA) has implemented the pilot program on a limited basis with its existing staff. Broader implementation could occur should SDA elect to redeploy a portion of a pre-existing federal grant to support enhanced staffing. Savings of $28,015 in FY 16 and $28,283 in FY 17 are recommended to reflect the elimination of state funding for this program.

Section 2. Provide Greater Flexibility in Managing the Children's Services Program. This section of the bill provides the Department of Rehabilitation Services with greater flexibility in hiring program staff by eliminating the use of specific position titles in statute. In addition, the need to estimate the benefit cost when determining the cost of teachers' salaries is no longer required given the transfer of fringe benefits to the Comptroller's Office. There is no net fiscal impact associated with this change.

Sections 3 - 8. Transition Coverage to Access Health CT. With changes under the Affordable Care Act, lower income households purchasing health insurance through Access Health CT, the state's health insurance marketplace, qualify for significant federal subsidies, lowering the costs associated with obtaining and maintaining comprehensive health insurance coverage. These federal subsidies include advanced premium tax credits to reduce the monthly cost of health insurance premiums as well as additional cost sharing reductions lowering the out-of-pocket, point-of-service costs for obtaining medical care and/or prescription drugs. With the previous barriers to accessing affordable health care removed, this bill transitions coverage for an estimated 34,200 HUSKY A adults (including pregnant women) with income over 138% of the federal poverty level to qualified health plans sold through Access Health CT. Coverage for children enrolled in HUSKY A will not be impacted. Savings to the state of $44.6 million in FY 16 and $82.1 million in FY 17 ($89.2 million in FY 16 and $164.2 million in FY 17 after factoring in the federal share) are anticipated.

In addition, this bill eliminates HUSKY B Band 3, which serves children whose families' incomes are over 323% of the federal poverty level and is unsubsidized. Enrollment under HUSKY B Band 3 has been steadily declining, with Band 3 now serving only 227 children as of February 1, 2015. Given the availability of affordable health insurance, there is no need to continue to administer this component.

Sections 9 and 10. Eliminate Cost of Living Adjustments for Clients on Public Assistance. Current statute provides recipients of Temporary Family Assistance, State Administered General Assistance and Aid to the Aged, Blind and Disabled a state-funded cost of living adjustment on July 1 of each year. This bill maintains the existing assistance levels by eliminating the projected standards increases of

1.7% in FY 16 and 1.5% in FY 17. It should be noted that Connecticut is one of the few states that allows TFA recipients to keep their earnings up to the federal poverty level. Savings of $2.4 million in FY 16 and $4.7 million in FY 17 are anticipated.

Section 10. Apply Annual Social Security Increases to Offset Costs under Aid to the Aged, Blind and Disabled (AABD). In past years, any cost of living adjustments (COLA) received as part of an AABD client's Social Security benefit were considered an increase in income and applied to the client's cost of care. As a result of a legislative change, effective FY 06, AABD clients now retain their Social Security COLA (by increasing the unearned income disregard) without a concurrent reduction in their state benefit. This bill reinstitutes the previous policy of applying any federal COLA to offset the cost of care. Savings of approximately $1.0 million in FY 16 and $1.9 million in FY 17 are anticipated.

Section 11. Remove Rate Increases for Nursing Homes. To comply with Department of Social Services (DSS) regulations, the current services budget includes inflationary increases estimated at 1.2% in FY 16 and 1.8% in FY 17. This bill eliminates these increases over the biennium. Even with this bill, Connecticut's rates will remain among the highest in the country. Savings of $6.4 million in FY 16 and $16.7 million in FY 17 ($12.9 million in FY 16 and $33.5 million in FY 17 after factoring in the federal share) are anticipated.

Section 12. Remove Rate Increases for Intermediate Care Facilities. To comply with DSS' regulations, the current services budget includes inflationary increases estimated at 1.7% in FY 16 and 1.9% in FY 17 for intermediate care facilities for individuals with intellectual disabilities. This bill eliminates these increases over the biennium. Savings of $500,000 in FY 16 and $1.1 million in FY 17 ($1.0 million in FY 16 and $2.2 million in FY 17 after factoring in the federal share) are anticipated.

Sections 13 and 14. Remove Rate Increases for Boarding Homes. Under current statute, DSS is required to annually determine rates for various boarding homes. Per DSS' regulations, boarding home rate increases are based on actual cost reports submitted by facilities, barring any legislation to remove rate increases for a particular fiscal year. Under the normal rate calculation structure, these homes would receive increases of 2.0%. This bill eliminates these increases over the biennium. Savings of $2.4 million in FY 16 and $5.1 million in FY 17 are anticipated.

Section 15. Restructure Pharmacy Reimbursement. This section of the bill implements two provisions included in the Governor's budget:

1. Increase Discount off the Average Wholesale Price. This bill reduces the reimbursement level to pharmacy providers from the average wholesale price (AWP) minus 16% to AWP minus 18% for brand name drugs. (In Connecticut, generic drugs are already governed by a maximum allowable cost reimbursement schedule.) Savings of $5.4 million in FY 16 and $5.9 million in FY 17 ($16.5 million in FY 16 and $18.0 million in FY 17 after factoring in the federal share) are anticipated.

2. Reduce Pharmacy Dispensing Fee. This bill reduces the dispensing fee for prescription drugs from $1.70 to $1.40 per prescription. Savings of $800,000 in FY 16 and $900,000 in FY 17 ($2.4 million in FY 16 and $2.6 million in FY 17 after factoring in the federal share) are anticipated.

Section 16. Eliminate Supplemental Pool of Funding for Low-Cost Hospitals. The legislature added funding beginning in FY 14 to increase the Medicaid base discharge rate for hospitals with a higher than average combined Medicare and Medicaid payer mix and less than average Medicaid expense per case. While this funding supports many of the state's smaller hospitals, it does not target resources to the hospitals that serve a high proportion of Medicaid clients. The hospitals that receive this funding have low Medicaid utilization and tend to serve patients with low acuity. In addition, some of the hospitals receiving this funding are part of larger hospital systems that are profitable and thus do not require a subsidy. Under this bill, the low-cost hospital pool is eliminated. Savings of $5.1 million in each year of the biennium ($15.1 million after factoring in the federal share) are anticipated.

Section 17. Ensure Total Payment to Ambulances Does Not Exceed Allowable Medicaid Rate. Current statute requires DSS to limit reimbursement to Medicaid providers for coinsurance and deductible payments under Medicare such that the combined Medicare and Medicaid payment to providers does not exceed the maximum allowable under the Medicaid program fee schedules. The statute, however, exempts ambulance providers whose rates are established by the Department of Public Health. This bill removes this exemption, thereby capping payments to ambulance providers to ensure that the combined Medicare and Medicaid payment to the provider does not exceed the allowable Medicaid rate. By doing so, these providers will be subject to the same standard that applies to all other Medicaid services. Savings of $4.3 million in FY 16 and $5.1 million in FY 17 ($8.6 million in FY 16 and $10.2 million in FY 17 after factoring in the federal share) are anticipated.

Section 18. Restructure State-Funded Connecticut Home Care Program. This section of the bill implements two provisions included in the Governor's budget:

1. Freeze Intake on Category 1. The state-funded Connecticut Home Care Program provides home and community-based services to elderly who are at risk of nursing home placement and meet the program's financial eligibility criteria. Given the state's fiscal situation, the Governor is proposing to close intake to Category 1, the lowest level of need under the current program. Category 1 is targeted to individuals who are at risk of hospitalization or short-term nursing facility placement but not frail enough to require long-term nursing facility care. These are not individuals who would immediately need nursing home placement in the absence of the program. This bill closes intake to Category 1 for new clients but does not impact existing clients. Category 2 of the state-funded program, which serves very frail elders with assets above Medicaid limits, and the state's Medicaid waiver program will remain open to new clients and will continue to provide services to the state's most vulnerable. Savings of $1.8

million in FY 16 and $5.6 million in FY 17 are anticipated.

2. Increase Cost Sharing. PA 09-5, September special session, introduced a client cost sharing requirement of 15% of the cost of care under the state-funded Connecticut Home Care program. This requirement was reduced to 6% under PA 10-179 and then increased to 7% under PA 11-6. Under this bill, the cost sharing requirement will be returned to 15%. The state's Medicaid waiver that provides similar services to the state's most vulnerable, based on their financial circumstances, will not be subject to cost sharing. Savings of $2.8 million in FY 16 and $3.0 million in FY 17 are anticipated.

Section 19. Reduce the Burial Benefit under the State Administered General Assistance (SAGA) Program. The SAGA burial benefit pays for funeral expenses of indigent persons who pass away without the ability to pay for the cost of a funeral or burial. The current burial benefit in Connecticut is $1,800. In comparison, surrounding states have a lower burial benefit. New York and Rhode Island both have a burial benefit of $900 while Massachusetts and Vermont have burial benefits of $1,100. This bill brings Connecticut's burial benefit in line with the surrounding states by reducing it to $1,000. Savings of $1.7 million in each year of the biennium are anticipated.

Sections 20 and 21. Reduce the Personal Needs Allowance for Residents of Long-Term Care Facilities. Social Security and other income received by residents of long-term care facilities are applied towards the cost of care except for a monthly personal needs allowance (PNA). Residents use funds for such items as gifts, clothing, cosmetics, grooming, personal phone, reading materials and entertainment outside of the facility. In 1998, Connecticut increased the PNA from the federal minimum of $30 to $50 per month and provided for July 1 annual updates equal to the inflation adjustment in Social Security income. As a result of the indexing to Social Security increases, the state's PNA was $69 per month in FY 10. PA 11-44 reduced this amount to $60 and eliminated the indexing. Under this bill, the PNA is further reduced from $60 to $50 per month, which is in line with the national average and is $20 above the federal minimum. It is also the same level as that of New York and Rhode Island. Savings of $1.0 million in FY 16 and $1.1 million in FY 17 ($2.0 million in FY 16 and $2.2 million in FY 17 after factoring in the federal share) are anticipated.

Section 22. Revise Medicare Part D Co-Pay Requirements for Dually Eligible Clients. Persons dually eligible for Medicare and Medicaid who are either institutionalized or receiving home and community-based services under Medicaid are not required to pay co-pays under the Medicare Part D program. In Connecticut, dually eligible clients, who are not institutionalized or receiving home and community-based services, are responsible for paying up to $15 per month in Medicare co-pays for Part D-covered drugs, with the state covering any costs that exceed this amount. Given that Connecticut is one of only a few states assisting dually eligible clients with the costs of these co-pays, which range from $1.20 to $6.60 in 2015, dually eligible clients will, under this bill, assume responsibility for covering the costs of all Medicare co-pays for Part D-covered

drugs. Savings of $80,000 in FY 16 and $90,000 in FY 17 are anticipated.

Section 23. Extend Nursing Home Moratorium. Current statute has a moratorium on the expansion of nursing home beds through FY 16. By permanently extending the moratorium, this bill supports the Governor's Strategic Rebalancing Plan to rebalance long-term services and supports and increase choice in where people receive these services and supports. In addition, the department's "right-sizing" initiative is helping nursing facilities address low census by diversifying or establishing new business models to support Medicaid recipients who need long-term services and supports to remain in the community. The bill also provides greater flexibility by providing a mechanism to close a facility and transfer beds to another facility. This bill is consistent with the Governor's budget, which does not assume any expansion in nursing home beds, and is expected to result in cost avoidance.

Section 24. Clarify Factors for Establishment of an Interim Close-Down Rate. This bill clarifies in statute that the department has the discretion to revise the rate of a nursing facility that is closing down and includes the factors that will be taken into consideration when determining the interim rate issued for the period during which a facility is closing down. By doing so, this bill will help contain costs when facilities close in the future and thus will result in cost avoidance.

Section 25. Clarify Transition to Statewide Rates for Hospital Inpatient Services. To modernize the Medicaid program's reimbursement methodology for inpatient hospital services and to align more closely with Medicare and other payers, DSS moved to a methodology based on diagnosis-related groups (DRGs) on January 1, 2015. While the conversion to this new system is to be cost neutral to the state, to mitigate the impact to some hospitals, DSS will be instituting hospital-specific base rates initially and will transition to a statewide rate over a five-year period. This bill clarifies in statute the department's intention to move to a single statewide rate and also clarifies that both Connecticut Children's Medical Center and John Dempsey Hospital will be exempt from the transition to a single statewide rate. This bill will help contain future costs and will result in cost avoidance.

Section 26. Strengthen Rebalancing Efforts. The Governor's Strategic Rebalancing Plan to rebalance long-term services and supports increases community options and supports consumers' informed choice. Recognizing that many people are looking for greater choice about where and how they receive long-term services and supports, this bill requires notification when nursing facility residents are expected to become Medicaid eligible. By doing so, this bill promotes freedom of choice by providing residents with access to information and services to return to the community if that is their preference. Aligning long-term services and supports with consumer choice and control will not only improve the quality of life for Medicaid participants but also reduce unnecessary expenses and institutionalization.

Sections 27 and 28. Repeal Certain Statutory Language. These sections of the bill implement the following provisions included in the Governor's budget:

1. Eliminate Family Support Grant (section 17b-616). The Family Support Grant provides a monthly subsidy to a parent or other family member of a child with a developmental disability. Currently, there are only 13 families receiving funding. This program is not a core function of the department and thus funding is eliminated in the Governor's budget for savings of $57,161 in each year of the biennium.

2. Eliminate Funding for Healthy Start (sections 17b-277a and 17b-277b). The Healthy Start program provides grants to provide risk assessment, care coordination, and case management services to low income pregnant women (under 250% of the federal poverty level) and children up to age two, and to assist women in obtaining Medicaid coverage for themselves and their children. In recent years, staff time has shifted from direct service to completing presumptive eligibility forms for HUSKY enrollment. This program is not a core function of the department and thus funding is eliminated in the Governor's budget for savings of $1.4 million in each year of the biennium.

3. Eliminate Funding for Adult Chiropractic Services (section 17b-278h). During the 2012 session, the legislature added funding to pay for services provided by independent chiropractors for adults under Medicaid. Because of concerns with the utilization and expenditures that could be incurred as a result of this expansion, expenditures are capped. As a result, the program is entirely state funded. This pool of funding is eliminated in the Governor's budget for savings of $250,000 in each year of the biennium.